Rural Health Collaborative Meeting Minutes
September 15, 2020
Time: 5:00pm to 7:00pm
Location: Virtual Meeting

The following Rural Health Collaborative (RHC) members were in attendance:

Christina Bartz, PA-C, MMS
Childlene Brooks
Joseph Ciotola, MD
Michael Clark, MS
Jennifer Dyott, DNP, CRNP, FNP C
Santo Grande, EdD
Roger Harrell, MHA
Matthew King, MD
Ken Kozel, MBA, FACHE
Maria Maguire, MD, MPP, FAAP
Maura Manley, MBA
Shelly Neal-Edwards, MSW
Sherry Perkins
Sara Rich, MPA
Timothy Shanahan, DO
April Sharp, LCSW
Anna Sierra, MS, EMT
Lorelly Solano, PhD
Mary Ann Thompson, RN
Sara Visintainer
Fredia Wadley, MD
William Webb, MS

Also in attendance: Sara Seitz, MPH, Director, State Office of Rural Health, Maryland Department of Health (MDH); Lindsey Snyder, Esq., Assistant Attorney General, MDH; Ron Bialek, MPP, Executive Director, RHC, and President, Public Health Foundation (PHF); Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF; Anastasia Brennan, BSN, RN, CPN, Intern, PHF; Kathleen McGrath, Director, Outreach and Community Health, University of Maryland Shore Regional Health (UM SRH); Arvin Singh, MBA, MPH, MHL, FACHE, Vice President, Strategy and Communications, UM SRH

Welcome and Review of Agenda
Joseph Ciotola, MD, Queen Anne's County Health Officer

Meeting was called to order at 5:00pm by RHC President Joseph Ciotola, MD. Dr. Ciotola welcomed everyone to the meeting.

Review and Approval of June 16, 2020 Meeting Minutes
Joseph Ciotola, MD, Queen Anne's County Health Officer

Dr. Ciotola requested any comments on the draft minutes for the June 16, 2020 meeting. No additions or corrections were provided. William Webb, MS, made a motion to approve the minutes as written. Fredia Wadley, MD, seconded the motion. The RHC unanimously approved the minutes.

Reprioritizing Work of the Rural Health Collaborative Based on the Realities of COVID-19
Joseph Ciotola, MD, Queen Anne's County Health Officer

Dr. Ciotola provided an update on discussion at the August 2020 RHC Executive Committee meeting about the RHC's work moving forward.

Final Report Structure and Sample Content
Fredia Wadley, MD, Health Officer, Talbot County Health Department

Dr. Wadley reviewed the history that lead to the establishment of the RHC, the RHC's work leading up to its December 2020 report, impacts of COVID-19, existing infrastructure in the Mid-Shore Region, potential rural health complex models, findings, and a proposed structure for the report. Presentation slides are attached.

RHC members discussed the requirements of the legislation establishing the RHC, COVID-19 response, Choptank Community Health System, mobile integrated health, criteria and objectives for rural health complexes, needs for implementation funding, federally qualified health centers, and next steps for the report.

Next Steps
Joseph Ciotola, MD, Queen Anne's County Health Officer

Dr. Ciotola wrapped up the meeting. PHF will draft the December 2020 report for RHC review. Meeting was adjourned at 6:03pm.

WORKING TOWARD FINAL RHC REPORT

FREDIA WADLEY, MD

SEPTEMBER 15, 2020

SUMMARY

- Potential closure of two hospitals in Mid-Shore Region (CON Process)
- MHCC WORKGROUP 14 TO 18 MONTHS IMPROVING RURAL HEALTH ACCESS & OUTCOMES (did not deal with hospital closures but adequate services)
- RURAL HEALTH COLLABORATIVE (improve access, health outcomes, & develop criteria, location for Rural Health Complex (some disappointed did not deal with hospital closures)
- Virtual versus bricks and mortar – latter not feasible for state funding (but legislation implied bricks and mortar sites, even criteria for location
- If Virtual, what are big components needed? What are some methods of getting virtual integration of services?

THEN CAME COVID-19

- Had to put a lot on hold to deal with COVID 19
- The virus helped to bring essential needs to forefront
- The most vulnerable people had Choptank Community Health; COVID testing when privates were not doing; open for business when private providers only seeing emergency
- Became crucial for vulnerable throughout the Eastern Shore; all races
- Choptank is bricks and mortar and has primary care, behavioral health, prenatal and dental services (greatest needs); served multiple counties
- Closer relationship with social services that private providers
- Why recreate the wheel? Why not add to the existing wheel?

CHARACTERISTICS OF CHOPTANK MATCHES GOALS OF RURAL HEALTH COMPLEX

- Improve health access, outcomes, for medically underserved populations
- Located in medically unserved areas that are defined
- Already adding behavioral health, prenatal, and dental services
- Has governing structure with consumers and providers from community
- Links with social support services for clients
- Even works on transportation problems for clients

Challenges are for resources to improve what already exists or increase capacity.

Hospital Outpatient Facility Model for Rural Health Complex

- Shore Regional has multiple offices close in Easton and outpatient facility in Denton
- AAMC has facility in Easton
- Hospitals could create Rural Health Complex with these if space available
- 4 basic clinical needs for region: primary care, behavioral health, prenatal and dental for first line care to prevent and manage chronic conditions
- Improve integration with social services
- Still take more funds to accomplish goals of Rural Health Complex

VIRTUAL MODEL FOR INTEGRATING SERVICES

- Should be done in every county & not just ones with Rural Health Complex
- MD made investment in "medical home" to coordinated care
- #1 statement of providers: "We cannot coordinate social services for patients in five different counties when they are so varied." We need "social home" to align with medical home
- CTO is not the answer for social services coordination, lack of staff
- Social services need to be coordinated, better and then try to coordinate with clinical services
- Multiple models in counties for better coordination of certain subpopulations, but there is a need for state and local efforts here for all vulnerable populations to better use existing services

CRITICAL FINDINGS FOR RECOMMENDATIONS (BC)

- US & states invest a lot in healthcare, but not in social support services that Impact health; large gaps in services available and not well integrated
- Reimbursement doesn't align with goal to produce more primary care and rural physicians
- MD's Total Cost of Care Waiver limited in incentives for hospitals to invest in ambulatory services to prevent unnecessary hospital usage
- Incentive reimbursement for outcomes has greater challenges for providers with lower income and greater health problems in clients (Remedy?)
- Teleheath has helped during pandemic and has more potential to help with transportation challenges forever present in rural areas; must address the burden for referring provider

CONTINUING CRITICAL FINDINGS

- To improve health outcomes, need focus on prevention and disease management, not medical specialists in rural areas: for identified needs RN for nurse practitioners, psychiatric NP, midwives; Social workers for behavioral health; dental hygienists for dental prevention
- Continuing with demonstration projects that die even when successful after funds are gone is not really making progress. Evaluation between funder and project could produce more evidence of benefit & potential funding.
- **OTHERS???**

FORMAT FOR REPORT

- **HISTORY** how we got here
- **NEEDS** in MID-SHORE AREA – FRONT LINE providers most important for better outcomes (primary care, behavioral health, prenatal, dental)
- **RECOMMENDATIONS FOR RURAL HEALTH IMPROVEMENT (BC)**
- **RECOMMENDATIONS FOR RURAL HEALTH COMPLEX**

  Purpose, components, criteria, location

  Three models: FQHC, Hospital Ambulatory Facility, Virtual

QUESTIONS?